Medicare and Home Health Care

This book explains . . .

- The home health benefit and who is eligible.
- What is covered by the Original Medicare Plan.
- How to find a home health agency.
- Where you can get more help.

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

HEALTH CARE FINANCING ADMINISTRATION
The Federal Medicare Agency

Page

What is Home Health Care?

Home Health Care is skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. This booklet explains Medicare's home health benefit and gives you information about where to get more information and help.

Who is Eligible for Home Health Care?

All Medicare beneficiaries can get home health care benefits, if they meet certain conditions. This booklet describes home health care benefits covered by the Original Medicare Plan. If you are in a Medicare managed care plan, see page 12.

How Can I Get Care at Home?

To get Medicare home health care you must meet these four conditions:

The plan of care is described on page 4.

You **must** meet all four of these conditions for Medicare to cover home health care.

1. Your doctor must decide that you need medical care in your home, and make a plan for your care at home; **and**
2. You must need at least one of the following: intermittent (and not full time) skilled nursing care, **or** physical therapy **or** speech language pathology services **or** continue to need occupational therapy; **and**
3. You must be homebound. This means that you are normally unable to leave home. Being homebound means that leaving home is a major effort. When you leave home, it must be infrequent, for a short time, or to get medical care, or to attend religious services; **and**
4. The home health agency caring for you must be approved by the Medicare program.

What Does the Original Medicare Plan Cover?

If you meet **all four** of the conditions above for home health care, Medicare will cover:

- Skilled nursing care on a part-time or intermittent basis. Skilled nursing care includes services and care that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed practical nurse).

Medicare will cover any of these kinds of therapy for as long as you are eligible and your doctor says you need them.

- **Home health aide services** on a part-time or intermittent basis. A home health aide does not have a nursing license. The aide provides services that support any services that the nurse provides. These services include help with personal care such as bathing, using the toilet, or dressing. These types of services do not need the skills of a licensed nurse. Medicare does not cover home health aide services unless you are also getting skilled care such as nursing care or other therapy. The home health aide services must be part of the home care for your illness or injury.
- **Physical therapy**, **speech language pathology services**, **and occupational therapy** for as long as your doctor says you need it. Medicare covers these types of therapy:

  1) **Physical therapy**, which includes exercise to regain movement and strength to a body area, and training on how to use special equipment or do daily activities, like how to get in and out of a wheelchair or bathtub.
  2) **Speech language pathology services**, which includes exercise to regain and strengthen speech skills.
  3) **Occupational therapy**, which helps you become able to do usual daily activities by yourself. You might learn new ways to eat, put on clothes, comb your hair, and new ways to do other usual daily activities. You may continue to receive occupational therapy even if you no longer need other skilled care.
- **Medical social services** to help you with social and emotional concerns related to your illness. This might include counseling or help in finding resources in your community.
- **Certain medical supplies**, like wound dressings, but not prescription drugs.
- **Medical equipment**, Medicare usually pays 80 percent of the approved amount for certain pieces of medical equipment, such as a wheelchair or walker.

The Original Medicare Plan covers these home health care services:

Medicare Services	Covered
Part-Time or Intermittent Skilled Nursing Care	✓
Part-Time or Intermittent Home Health Aide Services	✓
Physical and Occupational Therapy	✓
Speech Language Pathology Services	✓
Medical Social Services	✓
Medical Supplies (not drugs or biologicals)	✓
Durable Medical Equipment	✓*

*The Original Medicare Plan usually pays 80% of the approved amount for certain pieces of medical equipment. You may have to pay 20% of the approved amount for durable medical equipment. Ask your supplier "Do you accept assignment?" Assignment could save you money. For more information, call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of "Does your doctor or supplier accept assignment?"

What Doesn't the Original Medicare Plan Cover?

Medicare does **not** pay for the following:

- 24-hour per day care at home.
- Prescription drugs.
- Meals delivered to your home.
- Homemaker services like shopping, cleaning, and laundry.
- Personal care given by home health aides like bathing, using the toilet, or help in getting dressed when this is the **only** care you need.

What is a Plan of Care?

Your plan of care is written just for you. It describes the care you need, who should give the care, and any special equipment and foods that you might need.

A plan of care describes what kind of services and care you must get for your health problem. Your doctor will work with a home health care nurse to decide:

- What kind of services you need,
- What type of health care professional should give these services, and
- How often you will need the services.

Your plan may also include things like the kind of home medical equipment you need, what kind of special foods you need, and what your doctor expects from your treatment.

Your doctor and home health agency staff review your plan of care as often as necessary, but at least once every 60 days. If your health problems change, your plan of care will be reviewed and may change. Home health agency staff must tell your doctor right away if your health changes. You will continue to get home health care as long as you are eligible and your doctor says you need it.

Only your doctor can change your plan of care. Your home health agency cannot change your plan of care without getting your doctor's approval. You must be told of any changes in your plan of care. If you have a question about your care, you should call your doctor. If your agency changes your plan of care without your doctor's approval, you have the right to appeal. Your appeal rights are on the back of the Explanation of Medicare Benefits or Medicare Summary Notice that is mailed to you from the company that handles bills for Medicare. The notice will also tell you why Medicare didn't pay your bill and how you can appeal.

What Happens if I Am Not Getting the Care That I Need?

The home health agency will be careful to give you the care called for in your plan of care, without giving you extra services that have not been ordered by your doctor.

Your doctor works with the home health agency to make sure you get the care and services that you need. If you feel your medical needs are not being met, you should talk to both your doctor and the home health agency.

How Long Can I Get Home Health Services?

Medicare pays for your home health services for as long as you are eligible and your doctor says you need these services. However, the skilled nursing care and home health aide services are paid for only on a part-time or "intermittent" basis. This means there are limits on the number of hours per day and days per week that you can get skilled nursing or home health aide services.

Intermittent means you need home health care for a fairly short period of time.

To decide whether or not you are eligible for home health care, Medicare defines "intermittent" as:

- Skilled nursing care that is needed or given on fewer than seven days each week or less than eight hours each day over a period of 21 days (or less).

For example, Jane's doctor says that she needs a nurse to visit her every day for the next 15 days to care for a wound. The total time that the nurse will be at Jane's house will be less than an hour each day, and Jane only needs the nurse to come for 15 days. Jane's need for home health care meets the Medicare definition of "intermittent."

Your doctor can increase the number of hours per week you receive care.

Hour and day limits can be increased in special cases when the need for more care is limited and can be planned ahead.

Once you are getting home health care, Medicare uses the following definition of part-time or intermittent to make decisions about your coverage:

- Skilled nursing or home health aide services combined to total less than 8 hours per day and 28 or fewer hours each week.

For example, Fred has been getting home health care for 3 weeks. Fred's condition is improved, but his doctor would like Fred to continue to get home health care. Fred's doctor says that he needs a nurse to come in 3 days a week for 2 hours each day (a total of 6 hours) and a home health aide to come in 5 days a week for 3 hours each day (a total of 15 hours). This means that Fred is getting a total of 21 hours of home care per week, which meets Medicare's definition of "part-time or intermittent" home health care.

How Can Medicaid Help People with Low Incomes?

Medicaid is a joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. To qualify for Medicaid, you must have a low income and few savings or other assets.

Medicaid coverage differs from state to state. In all states, Medicaid pays for basic home health care and medical equipment. Medicaid may pay for homemaker, personal care, and other services that are not paid for by Medicare. Medicaid has programs that pay some or all of Medicare's premiums and may also pay Medicare deductibles and coinsurance for certain people who are entitled to Medicare and have a low income.

For more information about what Medicaid covers for home health care in your state, call your State medical assistance office. If you need the telephone number for your State, call 1-800-MEDICARE (1-800-633-4227 TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

The home health agency must tell you how much of your bill will be paid by Medicare.

What Does Medicare Pay For and What Can I Be Billed For?

Medicare pays the full approved cost of all covered home health visits. The home health agency sends bills to Medicare.

Before your care begins, the home health agency must tell you how much of your bill Medicare will pay. The agency must also tell you if any items or services they give you are not covered by Medicare, and how much you will have to pay for them. This must be explained both by talking with you and in writing.

You may be charged for:

- Medical services and supplies that Medicare does not pay for, such as prescription drugs.
- 20 percent coinsurance for Medicare covered medical equipment such as wheelchairs, walkers, and oxygen equipment. If the home health agency doesn't supply medical equipment directly, they will arrange for a home equipment supplier to get you the items you need.

If you are in the Original Medicare Plan, ask your supplier "Do you accept assignment?" Assignment could save you money. Call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of "Does your doctor or supplier accept 'assignment?'"

You are protected when your home health care ends.

How Does Medicare Pay for my Home Health Care?

Medicare pays your home health agency a set amount of money for each 60 days that you need care. (This 60 day period is called an "episode of care.") The payment is based on what kind of health care an average person in your situation would need. Medicare has paid hospitals in this way for many years.

What Do I Do if Medicare Stops Paying for my Home Health Care?

Home health agencies must give you a notice that explains why and when they think Medicare will stop paying for your home health care. If you get this notice and your doctor believes you still need home health care and that Medicare should keep paying, you can ask Medicare for an official decision.

To get an official decision, you must:

- Keep getting home health care if you think you need it. Ask how much it will cost. You should talk to your doctor and family about this.
- Understand you may have to pay the home health agency for these services.
- Ask the home health agency to send your claim to Medicare so that Medicare will decide if it will pay.

If Medicare decides to pay, you will get back all of your payments, except for any coinsurance for durable medical equipment.

What Do I Do if Medicare is Not Paying for an Item or Service that I Feel Should be Paid for?

If you are in the Original Medicare Plan, you can file an appeal if you think Medicare should have paid for, or did not pay enough for, an item or service you received. If you file an appeal, ask your doctor or provider for any information related to the bill that might help your case. Your appeal rights are on the back of the Explanation of Medicare Benefits or Medicare Summary Notice that is mailed to you from a company that handles bills for Medicare. The notice will also tell you why your bill was not paid and what appeal steps you can take.

How Do I Find an Approved Home Health Agency?

You can find a Medicare approved home health agency by:

- Asking your doctor or hospital discharge planner.
- Using a senior community referral service, or other community agencies who help you with your health care.
- Looking in your telephone directory in the Yellow Pages under "home care" or "home health care." (Look for home health care agencies that are Medicare approved.)

If your doctor decides you need home health care, you have the right to choose the home health agency to give you needed care and services. Your choice should be honored by your doctor, hospital discharge planner or other referring agency. Some hospitals have their own home health agency. You do not have to choose the hospital's agency. You may choose any agency that you feel will meet your medical needs.

It is important to remember that Medicare only pays for home health services that are given by a home health agency that meets Medicare's quality standards and is approved by Medicare. Medicare regularly inspects home health agencies to make sure that these standards are met.

Your home health agency must provide you with **all** the home care you need, both staff and medical supplies. The agency may do this through their own staff, through an arrangement with another agency, or they may hire someone else to meet your needs. This includes nurses, therapists, home health aides, and medical social service counselors (see pages 1 and 2).

When you start getting home care, Medicare approved home health agencies will ask you a set of questions about your health to help them give you proper care. The home health agency is required to keep this information confidential. You may ask to see this information. The home health agency will explain these questions to you, and give you written information about them.

Most home health agencies accept all Medicare patients. An agency is not required to accept you as a patient if they feel they cannot meet your medical needs. An agency cannot refuse to take you as a patient because of your condition, unless the agency also refuses to take other people with the same condition.

What Questions Do I Ask When I Choose a Home Health Agency?

Before you choose your home health agency, ask these important questions:

- Is the agency Medicare approved?
- How long has the agency been serving the community?
- Does this agency give the services I need?

- How are emergencies handled?
- Is the agency's staff on duty 24 hours a day, seven days a week?
- What will I be charged for services/supplies?
- Will Medicare or Medicaid pay for the items I need?
- How are my rights protected?
- Can my family and I help decide my plan of care?
- Does the agency teach family members about the type of care being given?
- Who makes sure that the home health care plan is being followed? Does the supervisor make regular visits to the home?
- Who can I call if I have questions or complaints?
- What happens if a home health agency staff person does not come when scheduled?
- Will the agency be in regular contact with my doctor?

What if I Want to Change Home Health Agencies?

Medicare will only pay for you to get care from one home health agency at a time. You may choose to end your relationship with one agency and choose another at any time. You must tell both the agency you are leaving and the new agency that you choose that you are changing home health agencies.

What if I am in a Managed Care Plan?

Medicare managed care plans are health care choices in some areas of the country. In most plans, you can only go to doctors, specialists, or hospitals on the plan's list. Medicare managed care plans must cover all Medicare Part A and Part B health care, including home health care.

If you belong to a Medicare managed care plan, you can only choose a home health agency that works with the managed care plan. Call your managed care plan if you have questions about the plan's home health care rules, coverage, appeal rights, and your costs. If you get services from a doctor or a home health care agency that doesn't work with the managed care plan, neither the plan nor Medicare will pay the bill. If you are not sure if you are in a Medicare managed care plan, you can call your local Social Security Administration (SSA) office, or call SSA at 1-800-772-1213. If you would like more information about Medicare managed care plans, call 1-800-MEDICARE (1-800-633-4227).

A counselor in your State Health Insurance Assistance Program can help answer your questions.

Where Can I Get Help with My Questions?

If you have questions about your Medicare home health care and you are in the Original Medicare Plan, call your Regional Home Health Intermediary (see pages 15 and 16). If you have questions about home health care and you are in a Medicare managed care plan, call your plan. If you are covered by another kind of supplemental insurance plan, call the plan's member services office.

Every State, territory, plus Puerto Rico, the Virgin Islands, and the District of Columbia, has a State Health Insurance Assistance Program (see pages 17-22) with counselors who will give you free health insurance information and help.

The counselors should be able to answer your questions about home health care and what Medicare, Medicaid, and other types of insurance pay for. In addition, these counselors will help you with Medicare payment questions; questions on buying a Medigap policy, or long-term care insurance; dealing with payment denials and appeals; Medicare rights and protections; sending complaints about your care or treatment; or choosing a Medicare health plan. You can find the phone number for your State Health Insurance Assistance Program on pages 17-22.

How Do I Complain About the Quality of My Care?

If you believe that the home health agency is not giving you good quality care, or you have a complaint about your home health agency, you should call your state home health hotline (see pages 17-22). Your home health agency should give you this number when you start getting home health services. Or you can call the Peer Review Organization (PRO) in your state to file a complaint (see pages 17-22).

How Do I Find and Report Fraud?

You are important in fighting Medicare fraud.

Most home health agencies are honest, and use correct billing information. Unfortunately, fraud occurs in the home health industry. It wastes Medicare dollars and takes money used to pay claims. You are important in the fight to prevent fraud, waste, and abuse in the Medicare program.

The best way to protect your home health benefit is to know what Medicare covers, and to know what your doctor has planned for you. If you do not understand something in your plan of care, ask questions.

To report Medicare fraud, call 1-800-447-TIPS (1-800-447-8477).

You should look for:

- Home health visits that your doctor orders that you never get.
- Visits by home health staff that are not needed.
- Bills for services and equipment you never get.
- Faking your signature or your doctor's signature.
- Pressure to accept items and services that you do not need.
- Items listed on your Medicare Summary Notice or Explanation of Medicare Benefits that you do not think you received.

You also should be careful about activities such as:

- Home health services your doctor did not order. The doctor who approves home health services for you should know you, and should be involved in your care. If your plan of care changes, make sure that your doctor was involved in making those changes.
- A home health agency that offers you free goods or services in exchange for your Medicare number. Treat your Medicare card like a credit card or cash. Never give your Medicare or Medicaid number to people who tell you a service is free, but they need your number for their records.

To report any suspected home health care fraud, call the Regional Home Health Intermediary for your state (see pages 15 and 16), or call 1-800-447-TIPS (1-800-447-8477). Each call is taken seriously.

Important Telephone Numbers

The following pages have telephone numbers that you can use if you need more information.

Note: At the time of printing, telephone numbers listed were correct. Phone numbers sometimes change. To get the most up-to-date phone numbers, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) or go to www.medicare.gov on the Internet and select "Helpful Contacts".

Pages 15-24 of this publication are intentionally left blank. They contain phone numbers. For the most recent contact information within this section, please visit the Helpful Contacts section of this site.

Appeal: An appeal is a special kind of complaint you make if you disagree with a decision about your health care services. For example, if Medicare doesn't pay for a service you got. This complaint is made to your Medicare health plan or the Original Medicare Plan. There is usually a special process you must use to make your complaint.

Approved Amount: The fee Medicare sets as reasonable for a covered medical service. It may be less than the actual amount charged. Approved amount is sometimes called "approved charge."

Durable Medical Equipment: Medical equipment that is ordered by a doctor for use in the home. These items must be reusable, such as walkers, wheelchairs, or hospital beds.

Homebound: Normally unable to leave home. Leaving home takes considerable and taxing effort. A person may leave home for medical treatment or short, infrequent absences for nonmedical reasons, such as a trip to the barber, or attend religious services. A need for adult day care does not keep you from getting home health care for other medical conditions.

Home Health Agency: An organization that provides home care services, including skilled nursing care, physical therapy, occupational therapy, speech therapy, and care by home health aides.

Home Health Care: Skilled nursing care and certain other health care that you get in your home for the treatment of an illness or injury.

Medicaid: A joint Federal and State program that helps with medical costs for some people with low incomes. Programs vary from State to State, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medicare: A health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (ESRD) (people with permanent kidney failure who need dialysis or a transplant).

Medicare Managed Care Plan: These are health care choices in some areas of the country. In most plans you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.

Original Medicare Plan: A pay-per-visit health plan that lets you go to any doctor, hospital, or other health care provider who accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amounts, and you pay your share (coinsurance). The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

Plan Of Care: A plan written by your doctor that describes what kind of services and care you must receive for your health problem.

Peer Review Organization (PRO): Groups of praticing doctors and other health care experts paid by the Federal Government to monitor and improve the care given to Medicare patients. They must review your complaints about the quality of care provided by inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare managed care plans, and ambulatory surgical centers.

Provider: A doctor, hospital, health care professional, or health care facility.

Regional Home Health Intermediary: A private company that contracts with Medicare to process claims and make checks of home health care.

Skilled Nursing Care: A level of care that must be given or supervised by licensed nurses and is under the general direction of a doctor. All of your needs are taken care of with this type of service, including giving direct services. Examples of skilled nursing care are: getting intravenous injections, tube feeding, oxygen to help you breathe, and changing sterile dressings on a wound. Any service that could be safely performed by an average nonmedical person (or one's self) without the direct supervision of a licensed nurse is not covered.

State Health Insurance Assistance Program (SHIP): A State organization that receives money from the Federal Government to give free health insurance counseling and assistance to Medicare beneficiaries.

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